

## Can We Train Basic Empathy? A Phenomenological Proposal

Within the field of nursing, there is widespread agreement that empathy is key to effective clinical practice. In light of this view, many nursing programs incorporate empathy training into their curricula. But what does it mean to train empathy? In the nursing literature, the concept of empathy refers to a broad array of emotional, cognitive, and behavioral phenomena. And its meaning often overlaps with a number of other key concepts in the literature, such as sympathy, care, and compassion. Reviews of empathy education in nursing point to this conceptual confusion as a major stumbling block to the design, implementation, and evaluation of empathy training (see, e.g., Brunero et al., 2010; Williams and Stickley, 2010).<sup>1</sup>

In this article, we put forward a conceptualization of basic empathy that is narrower and more specific than what is commonly used in the nursing literature.<sup>2</sup> Then, we briefly outline how this conceptualization may provide a foundation for empathy training programs. Rather than draw from the fields of psychology or cognitive and affective neuroscience, which have had a major influence on the conceptualization of empathy in nursing, we instead turn to the philosophical tradition of phenomenology. Other phenomenological concepts, such as skilled coping or embodied know-how (Benner, 1984), have successfully informed nursing research, education, and practice. The phenomenological concept of empathy has recently received some attention in the nursing literature (see, e.g., Morgan, 2017; van Dijke et al., 2020; Fernandez and Zahavi 2020); but its potential for guiding nursing education has not yet been adequately explored.<sup>3</sup> In what follows, we define the phenomenological concept of empathy and consider how this concept can inform approaches to empathy training.

### A Phenomenological Conceptualization of Empathy

Discussions of empathy in the nursing literature often rely upon concepts borrowed from psychology and neuroscience. In particular, nurses often rely on the distinction between cognitive and emotional empathy (see Bloom 2014).<sup>4</sup> Cognitive empathy involves the use of higher-level intellectual processes to understand another's experience; these processes may include imaginative perspective taking, critical thinking, or inference, among other techniques. Emotional empathy, in contrast, is understood as the ability to experience and understand another by reproducing and sharing their affective state; you understand the other's experience by feeling the same way that they feel.

This dichotomy, however, neglects a more fundamental kind of empathy that both cognitive and emotional empathy rely upon. We call this "basic empathy." According to phenomenologists, including Max Scheler, Edmund Husserl, and Edith Stein, the most basic form of empathy acquaints you—in the most direct and immediate manner possible—with another's experiential life. Importantly, on this account empathy is not about me having the

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<sup>1</sup> The failure to define empathy and the impact this failure on medicine and medical education are also well-documented (see, e.g., Pedersen 2009; Sulzer, Feinstein, and Wendland 2016). Moreover, in empathy research more broadly, Judith Hall and Rachel Schwartz argue that researchers should simply stop using the broad term "empathy" and instead use narrower terms that refer specifically to what they aim to study (Hall and Schwartz 2019). We're grateful an anonymous reviewer for bringing these articles to our attention.

<sup>2</sup> For a more detailed explication of this concept, including how it differs from concepts of empathy commonly used in the nursing literature, see (Fernandez and Zahavi 2020).

<sup>3</sup> The only work on phenomenological empathy training is by Magnus Englander (2019, 2014). However, his approach focuses on empathy training in higher education and is not specific to nursing. In light of concerns that nurses' needs differ in important respects from other caring professions, such as psychotherapy (see, e.g., Morse et al., 1992), we here focus exclusively on health care.

<sup>4</sup> This distinction overlaps with the distinction between "clinical" or "trained" empathy, on the one hand, and "basic" or "trait" empathy, on the other (see, e.g., Alligood, 1992). However, the overlap is only partial. For the sake of simplicity, we limit ourselves to engaging with the psychological distinction between cognitive and emotional empathy.

same mental state as the other, but about me being experientially acquainted with an experience that is not my own. That is also why the phenomenologists often use the term “empathy” interchangeably with terms such as “other-experience” or “other-perception” (Husserl, [1932] 1960, p. 92; Scheler, [1923] 2008, p. 220). Moreover, the concept of basic empathy is used in two different, but closely related, senses. First, it refers to the capacity to perceive human bodies as expressive subjects, as minded beings, rather than as mere objects; second, it refers to our ability to perceive what the other is experiencing or doing, say, being sad, or insecure, or trying to reach for the bedpan. We’ll return to these two aspects of basic empathy in the following section. But, for now, let’s get a clearer sense of basic empathy with a concrete example.

If you see a dog running toward your friend and your friend suddenly tenses her muscles and stands erect, you immediately perceive your friend as afraid of the dog—and, in turn, perceive the dog as a fearsome object in her lived world. On the one hand, you didn’t need to reason your way to this understanding by cataloguing various features of your friend’s posture or facial expression and concluding that she must be afraid. On the other hand, you didn’t need to feel afraid of the dog yourself to perceive your friend’s fear. Rather, we simply perceive bodily movements and gestures as expressive of desires, intentions, emotions, attitudes, and so on. It’s only in cases where we perceive the meaning of someone’s expressive behavior as ambiguous, or we otherwise have some reason to doubt our immediate understanding, that we turn to other cognitive or emotional techniques for making sense of others.

One may argue that emotional empathy, like basic empathy, also provides an immediate understanding of the other. But consider the following example: You bump into a man on the street and he turns on you with a scowl—you immediately perceive him as angry. It’s certainly possible that, in this moment, you experience anger in response to his anger. But what if, instead of anger, you experienced fear, surprise, or concern? In all of these cases, you may still experience the man as angry. So, it’s not your anger that allows you to understand him as angry. Rather, anger, fear, surprise, or concern are all *reactions* to his anger. And, in virtue of being reactions, all of these states require that you already had an understanding of him as angry—an understanding provided by your capacity of basic empathy.

One key feature of basic empathy—and one that’s often misunderstood when we think that emotional empathy is the most basic way of understanding others—is that it does not involve emotional contagion or a fusion of identities. Following on our example above, when I perceive my friend as afraid or the man as angry, I perceive the fear or anger *in them*. I may, in reaction to their subjective state, become angry, afraid, surprised, or concerned; but it’s not my feeling that provides the understanding of the other. We only feel the way that we do because we already understand the other as expressing a particular state. Here, we have provided only a brief introduction to the phenomenological concept of basic empathy. But the concept is developed in considerable detail in both classical and contemporary works (Husserl [1931] 1960; Scheler [1923] 2008; Stein [1917] 1989; Zahavi 2010; 2011; 2014; 2017; 2019).

### **How Can We Train Basic Empathy?**

How can this understanding of empathy inform clinical practice? Basic empathy is a capacity that we all have. Excepting certain pathologies, infants manifest an innate sensitivity to social stimuli and come equipped with an innate, automatic, and pre-reflective ability to tune in to and respond to the expressive behavior of others (Rochat and Striano 1999). However, this is not to say that basic empathy cannot be obstructed and, conversely, also facilitated.<sup>5</sup>

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<sup>5</sup> Christine Sorrell Dinkins makes a similar argument in favor of William James’ pragmatist account of empathy. She says that rather than teach empathy, we might instead focus on unblocking empathy (Dinkins, 2018).

How can basic empathy be obstructed? Remember that the concept refers to two related capacities: First, the ability to perceive other human bodies as expressive subjects rather than mere objects; second, the ability to perceive the particular state that another human subject is in. There are certain kinds of attitudes, such as a scientific attitude, that allow us to perceive human bodies as mere objects—for instance, as complex biological organisms susceptible to disorder and dysfunction. There are, of course, cases where this kind of objectification is warranted and even required, such as when a surgeon is performing an operation. But some phenomenologists have expressed concern that healthcare professionals sometimes objectify their patients in ways that have a dehumanizing effect. Drew Leder, for instance, says, “...the doctor examines a *physical* body. Much of her/his medical training has de-emphasized lived embodiment from the first ‘patient’ encounter – that with a cadaver. The predominant task at hand is to search for a mechanical precipitant of disease, be it toxin, trauma, or bug” (Leder 1984, p. 33). He’s concerned that this view of the body can also become the patient’s own view, thereby creating the experience of one’s own body as distant or alien.<sup>6</sup>

This is not, however, our primary concern when it comes to how healthcare professionals understand their patients. Rather, a more frequent problem concerns cases where others’ expressions and expressive behavior, which we understand through basic empathy, are ambiguous or opaque. In such cases, we typically turn to other strategies for understanding the other, such as techniques often referred to under the heading of cognitive empathy. We suggest that some of these techniques actually risk covering over or obscuring the other’s experience. And we propose an alternative that relies upon, rather than obstructs, our capacity for basic empathy.

Consider the following example: A patient comes to your clinic complaining of pain after a miscarriage. It’s not immediately clear to you what the source of the pain is, so you and your team provide her with a full checkup and run the relevant diagnostic tests. In the end, you do not find anything to suggest that her pain has a physiological cause. In this situation, here are three ways that you might go about understanding and treating her pain.

1. **Theorizing:** You know that pain can often have a psychological rather than a somatic cause. Drawing on this theoretical understanding, you conclude that the miscarriage must have been psychologically traumatizing and, therefore, while she does feel pain, it’s “all in her head.” Based on this theoretical understanding, you assure her that, with some time, she’ll feel well again.
2. **Imaginative perspective taking:** You had a miscarriage some years ago and recall that, while the experience was distressing, you coped with these feelings and felt considerably better after a few weeks. When trying to put yourself in her place, you project your own experience onto her and expect her to feel the same way that you felt after your miscarriage. You consequently assure her that these feelings are nothing to worry about; they won’t last long and, like you, she will soon feel well again.
3. **Openness:** Rather than draw on psychological theories or your own past experiences, you approach the patient from a standpoint of humility. You realize, for instance, that the pain she reports might at first seem relatively insignificant to you because, if you

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However, the definition of empathy that she operates with is much broader than the specific phenomenological focus that we have taken here.

<sup>6</sup> For a detailed overview of how the phenomenological concept of embodiment has been used to understand experiences of illness and health care, see (Fernandez 2020).

were in genuine pain, you would express it differently. Instead of projecting your own experience onto her, you acknowledge that what you take her to be expressing may not be exactly what she intended to express. You invite her to more fully and accurately express herself—whether through linguistic or bodily expression—so that you can develop a more accurate understanding of her experience.

By providing these three styles of understanding, we do not mean to suggest that theoretical or imaginative-projective techniques are never useful in a clinical setting. Rather, we want to point out that these two modes of understanding in some situations risk covering over the other's experience rather than bringing it to light. They will certainly provide *some* understanding of the other; but they also risk violating and doing away with the patient's own perspective altogether. In short, they risk obscuring or undermining the kind of understanding that basic empathy offers, the kind of understanding that attends to the patient in the here and now. By initially putting the two former techniques to the side and starting from an attitude of openness, one might better be able to understand the patient in their individuality and from their particular situation.

If empathy training programs begin by acknowledging that the most prevalent way in which we understand others is through basic empathy, then such programs should not focus on teaching us empathic skills, but on unlearning some of the acquired skills that threaten to obstruct our basic empathy. In addition, it might be important to acquire techniques that effectively supplement basic empathy while maintaining an attitude of openness toward the patient, such as techniques for soliciting patient narratives. Such an approach may provide a more focused and effective means of training empathy and supporting genuine encounters between healthcare professionals and patients.

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